



COMPLETE YOUR FORMS | MEDICAL INFORMATION

Return all documents to Sedgwick in one of three ways:

upload: mySedgwick® | email: WalmartForms@sedgwickslr.com | fax: 859-264-4372 or 859-280-3270

Associate name: John Dallinga

Associate WIN: 229298296

Case number: 4A2502CWL190001GI

PART B: AMOUNT OF LEAVE NEEDED

5. Will the associate be required to be away from work for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ No ☒ Yes

If so, provide an estimate of the continuous dates the associate will be away from work:

Start date: 2/5/25 End date: 5/19/25

6. Will the associate need to attend follow-up treatment appointments because of the associate's medical condition? ☐ No ☒ Yes

If so, are the treatments medically necessary? ☐ No ☒ Yes

Estimate the treatment schedule, if any. Include the dates of any scheduled appointments and the time required for each appointment, including any travel time and any recovery period. **Please provide a numerical response** – For example: 1 appointment every 3 months, and requires 1 day of recovery per appointment:

Frequency: 1-2 appointment(s) every week(s) or 3 month(s)

Duration: 4 hour(s) or day(s) per appointment

7. Will the condition cause episodic flare-ups periodically preventing the associate from performing his/her job functions? ☐ No ☒ Yes

Is it medically necessary for the associate to be absent from work during the flare-ups? ☐ No ☒ Yes

If so, explain: IF he develops shortness of breath, he will be unable to work.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of time the patient may need to be away over the next 6 months. **Please provide a numerical response** – For example: 1 episode every 3 months lasting 1-2 days:

Frequency: 1 time(s) per week(s) or 2-3 month(s)

Duration: 8 hour(s) or day(s) per episode

8. Will the associate need to work part-time or on a reduced schedule because of the associate's medical condition? ☒ No ☐ Yes

If so, is the reduced number of hours of work medically necessary? ☐ No ☐ Yes

Estimate the part-time or reduced work schedule the associate needs, if any:

 hour(s) per day; day(s) per week from through

ADDITIONAL INFORMATION: Please reference the question number for any related information you provide

R. W. Lee
Signature of healthcare provider

4/9/25
Date

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